Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BOB M HOLLANDER DC
3100 TIMMONS LN STE 250
HOUSTON TX 77027

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0012-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to properly pay the claim even after it was sent to carrier for reconsideration. I have left several messages for the adjuster and did not get a call back."

Amount in Dispute: $259.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The respondent recommended a total of $432.10 reimbursement for 10 units at $43.21. The 6 units in the amount of $259.26 was denied with ANSI code 150, as the documentation submitted did not support 16 units of the FCE. ANSI code 97 was also used with the reason for denial being that interpretation/reports are global of the reimbursement for the FCE service. …The respondent supports this determination based on the AMA CPT Code description: 97750 is a 'Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.' The documentation indicates the 'Total Test/Evaluation Time 4 hrs (including interview, intake, examination, functional testing, in 9:01 am out 11:22, and interpretations/reports – 1 hr 24)'. The documented in and out times are 9:01 to 11:22. This supports 2 hours and 21 minutes or 141 minutes. 141 divided by 15 equals 9.4 units. 10 units at $43.21 was reimbursed. The disputed 6 units or 90 minutes was denied due to the documented time spent performing 'interpretation/reports – 1 hr 24.' Since the AMA Code description states 'with written report,' this time spent performing interpretation and reports is an integral part of the reimbursement rate. The respondent maintains its position that the requestor was properly reimbursed in accordance with the TDI DWC rule 134.204, based on the timed documentation provided by the requestor."

Response Submitted by: Gregory D. Solcher, Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2010	97750-FC	$259.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 06, 2010, August 09, 2010
   - 97 – Payment is included in the allowance for another service/procedure
   - 150 - Payment adjusted because the payer deems the information submitted does not support this level of service.
     Comments:
   - 97 – INTERPRETATION/REPORTS ARE GLOBAL OF THE REIMBURSEMENT FOR THE FCE SERVICE.
   - 150 – DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE LEVEL OF SERVICE FOR 16 UNITS OF FCE. REIMBURSEMENT MADE FOR 2 HRS AND 26 MINUTES OF FCE AS DOCUMENTED.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Is the written report global to the Functional Capacity Evaluation (FCE)?
2. Does the submitted documentation support the level of service for the 16 units billed?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Tex. Admin. Code §133.204(b)(1) requires that "Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes." The AMA CPT code that defines the service in dispute (CPT Code 97750) is found in the "Test and Measurements" section of the Medicine/Physical Medicine and Rehabilitation section of the 2010 AMA CPT code book. AMA CPT states that tests and measurements require direct one-on-one patient contact. Code 97750 is described as a "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), **with written report** (emphasis only), each 15 minutes…" CPT code 97750 should be billed in 15 minute increments for time that the provider of services spends in direct, one-on-one contact with the injured worker. Therefore, the written report is global to the FCE performed for this date of service.
2. The requestor explains in the medical documentation that "Total Test/Evaluation Time 4.0 Hrs (Includes Interview/translation, intake/translation and questions, examination, functional testing, in 9:01 am-out 11:22, and interpretation/reports 1 hr 24 mins)". Review of the CMS-1500 finds that the requestor billed 16 units for $691.36. Documented in and out times are 9:01 am to 11:22 am for 2 hours and 21 minutes (141 minutes=9.4 Units) for one-on-one patient contact for the FCE performed. The remaining 1 hr 21 minutes (81 minutes=5.4 Units) was for interpretation/reports.
3. The respondent reimbursed the requestor $432.10 for 10 units. Therefore, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Pat DeVries	October 19, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.